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Certificate of Need Long-Term Care Capacity Rulemaking Advisory Committee (RAC)

October 21, 2026
9:00 am via Microsoft Teams

RAC MEMBER ATTENDEES

Andrew Rapp	Regency Pacific Management
Danielle Meyer	Hospital Association of Oregon
Emily Sokolski	SEIU 503
Eugenia Liu	Oregon Health Care Association
Jody Corona	Health Facilities Planning & Development
Justin Hurley Braswell	Rubicon Investments
Kristin Milligan	LeadingAge Oregon
Jonathan Edwards	Good Shepherd Health Care System
Marcus Roshak	Sapphire Health Services
Peter Stoloff	Peter Stoloff, P.C., Attorney
Steve Fogg	Marquis Companies

OTHER INTERESTED PARTY ATTENDEES

Jim Savory	Public
Libby Batlan	Oregon Health Care Association
Lucas Bradshaw	Good Shepherd Health Care System
Marissa Fritz	Hospital Association of Oregon

OHA and ODHS ATTENDEES

Andrea Ogston	DOJ
David Allm	ODHS-SOQ
Dana Selover	PHD-HCRQI
Jeremiah Adams	ODHS-SOQ
Justin Withem	ODHS
Matt Gilman	PHD-HCRQI
Mellony Bernal	PHD-HCRQI
Sadie Morrissey	PHD-HCRQI

WELCOME AND MEETING PROCEDURES

Mellony Bernal welcomed RAC members, reviewed the agenda, and went over meeting procedures and expectations.

- Meeting is being recorded and all information shared is a matter of public record and may be disclosed.
- Per OHA policy, members of the public may observe only. Should public members have information they would like to share, they can send information by email to mellony.c.bernal@oha.oregon.gov, matt.s.gilman@oha.oregon.gov or sadie.morrissey@oha.oregon.gov following the meeting. Any information received will be shared with RAC members and OHA staff.
- Microsoft Teams features such as Chat and Raise Hand features were reviewed and instructions on how to communicate during the RAC were shared.
- Information about the Health Care Regulation and Quality Improvement (HCRQI) Section's rulemaking activity website was shared including where people can find information about new and amended rules, temporary rules, proposed rules, and other relevant information. (http://healthoregon.org/hcrqirules)

INTRODUCTIONS

In lieu of introductions, RAC members were asked to share name and organization in the Chat.

ADMINISTRATIVE RULE REVIEW

Dana Selover opened discussion on rule revisions based on previous RAC meetings:

OAR 333-610-0000 - General

Section (3) was added based on previous RAC feedback which reiterates legislative findings and policy relating to Certificate of Need for health services.

RAC members expressed support for this additional language in the Chat.

OAR 333-610-0010 - Definitions

The definition for "Alternative Services" was amended correcting the rule reference citation. The definition for "Institutional Level of Care" was

removed as it is not used in the rules. The definition for "Set-up Beds" was removed in response to information shared in previous RAC meetings.

- RAC member asked why definition of "set-up beds" was removed. Andrea Ogston noted that for purposes of long-term care beds the role of the Certificate of Need (CN) program is to defer to the Oregon Department of Human Services (ODHS) and based on previous RAC discussions, the ODHS does not have a definition for "set-up beds" in existing rules. These rules were amended to allow an applicant to submit documentation that there is a shortage of available beds in a specific county or local area to address situations where the number of licensed beds may not match the number of beds available for use. This change is seen as a better way to measure actual need.
- RAC member asked via Chat what percentage of the licensed beds are actually staffed and noted that using licensed beds creates an artificially low occupancy threshold.
- RAC member questioned why ODHS can't have a rule for "set-up beds" and noted that the new provision is too vague, does not mention "set-up beds" and stated that effectively these rules would mean there is no need for additional nursing home beds in Oregon, so why not promulgate a rule stating such. This RAC member further expressed dissatisfaction with the rules as currently constructed, stating that "nobody's even close to 85% occupancy in any county" of licensed beds. He further noted that licensed beds are "phantom beds" because a lot of the beds are not set-up for a reason.
- D. Selover noted that the purpose of these rules is to be able to evaluate a CN application since the current rules are so out-of-date and the statute requires review. She deferred any response regarding the definition of "set-up beds" to ODHS.
- The RAC member continued to express discontent with removal of the term "set-up beds" particularly since the annual nursing facility application requires facilities to identify their "set-up beds."

OAR 333-610-0020 - Principles

Subsections (1)(a) through (e), subsections (3)(a) through (d), and section (4) were amended. Based on RAC feedback, A. Ogston shared the purpose of the amendments was to make criteria for determining need for nursing home

beds more specific and closely tied to actual community need. The goal is to ensure that each factor used to assess need has a clear connection to the availability of skilled nursing facility beds. Key changes include:

- Refining measures related to hospital discharge delays so they focus on delays caused by a lack of available nursing facility beds, rather than unrelated issues. A. Ogston acknowledged that payer source, guardianship issues or non-capacity related factors is broad and that if this data is too difficult to obtain then additional suggestions would be encouraged.
- Adjusting travel time and distance measures to reflect local circumstances, recognizing that travel expectations differ between rural and urban areas.
- Requiring specialized bed needs, such as behavioral health or other specific services, be linked to demonstrated demand within the local county.
- Creating a way to account for situations where licensed beds exist on paper but are not realistically available for use, while avoiding assumptions based solely on a facility's staffing choices.
- Strengthening the connection between hospital readmissions and the need for additional nursing facility capacity.

Discussion (Section 1):

- RAC member expressed that subsections (1)(a) and (1)(c) seem too narrow and should be reconsidered. Further discussion on subsection (1)(a) suggested that the sentence end after the term 'delays' and the rest be deleted.
- RAC member apologized for lateness of comments sent this morning and indicated that they want to ensure that the data can be captured and that interested and affected parties have access to the same data. They asked where someone can access data for payer source and guardianship and these data publicly available? They also stated that clinically appropriate nursing facility options are going to be challenging. Where would someone get hospital readmission data given that only limited data is available from CMS? Staff noted that based on discussion, they will ensure that the data stated in the proposed rules is available from at least one source and expressed the need that rules must remain flexible.

- RAC member stated they are sensitive to the challenges around the proposed rules and noted that some of the factors being discussed represent only a small portion of the overall demand for skilled nursing facility beds. If an applicant uses one of these smaller, specialized needs to justify new beds, the CN approval should closely match the actual need. Additionally, addressing the difference between licensed beds and beds that are actually available for use, the RAC member expressed concern about the term "reasonably" which is too vague. The lack of a clear definition could lead to subjective decisions and inconsistent interpretations. More specific criteria, such as timelines or other measurable standards, should be considered to clarify when licensed beds should be considered available.
- RAC member expressed the importance of creating rules that lead to meaningful and consistent results. Measures such as hospital discharge delays can be influenced by factors such as payer source or barriers that prevent movement to appropriate care setting. This RAC member noted the importance of running an analysis.
- RAC member asked why the last sentence under subsection (1)(a) was deleted, noting that it appears to make the rules lean too heavily toward counting only licensed beds. A. Ogston noted that the sentence referred to was moved to the top of paragraph but worded slightly differently to be broader. D. Selover shared that the reference to "clinically appropriate" was to try and account for specialty beds such as ventilator care, behavioral health, etc. It was also noted that based on previous RAC comments, not every discharge delay can be tracked back that a patient needs a nursing facility bed versus something else. RAC member expressed that a previous comment referencing 'setting beds back up' means to take licensed beds and set them back up so they are available for use which is the whole issue – licensed beds not available for use. The rules, as amended, do not take this into consideration.
- In response to comments about the term "reasonably," A. Ogston noted that in a different set of CN rules, the program looks at the prior two years as an indication of what beds are really available. It was expressed that this may not work for nursing beds because decisions are more complicated. If there is some mechanism to evaluate the term 'reasonably,' RAC members were encouraged to share.

- RAC member expressed that it's important to consider the long-term history of the industry in Oregon. Demand for skilled nursing facility beds has declined since the 1980s which is one reason why licensed beds are not put into service. There is not enough demand to justify using all the licensed capacity. However, that trend is changing as the baby boomer population ages. This will give existing facilities the opportunity to take non-set-up beds and redeploy them.
- RAC member stated that being able to set up licensed beds leverages economy of scale already in place (costs/reimbursement), which you cannot get through building a new facility.

Discussion (sections 3 & 4):

- A. Ogston reiterated that based on previous feedback about the availability of utilization data, the program will need to consider further. The changes in section (3) were made to align more closely with ODHS and A. Ogston acknowledged that while comments received previously about nursing facility use increasing among younger people, the State Plan on Aging is still important to connect back to ODHS. It was noted that for section (4), language was updated to acknowledge that while a state policy exists regarding the least restrictive setting, people still get to choose. As such, use rates should reflect this choice.
- RAC member noted that with respect to hospital referral patterns, Apprise data does not include location of the skilled nursing facility the individual was discharged to.

Discussion (section 7):

- RAC member reiterated their objection to removing "set-up" beds in this rule and all other rules. A. Ogston acknowledged concerns that the proposed revisions for considering available licensed beds may not be adequate. It was further noted that the goal of the proposed revisions is to allow consideration of local constraints when there is reliable data to support. RAC member asked if the position of the state is to allow skilled nursing facilities the right of first refusal to increase beds to the detriment of any possible new entrants? D. Selover responded that no final decisions on rule language have been made and emphasized that any Certificate of Need application must follow existing laws and agency policies, regardless of the type of healthcare service involved, such as hospitals, inpatient

rehabilitation, psychiatric care, or long-term care. All the information received will be considered.

OAR 333-610-0030 – Need

A. Ogston noted that based on previous discussions, concerns were expressed about when OHA would use something other than the county as a service area. Subsection (1)(b) was amended to clarify what an applicant would need to show to use a multi-county service area based on evidence. The main principle was retained and changes were meant to clarify how it would be evaluated. Section (2) was modified, replacing five years with three years relating to utilization data in response to feedback from the Oregon Department of Human Services. The term "set-up" beds was removed from several sections. Section (3) noted that the Authority may request documentation from facilities to confirm licensed bed counts. Section (5) clarified that the applicant is responsible for explaining any data smoothing methodology. Minor changes were made to section (7) and included a change related to chronic understaffing under subsection (7)(d) and hospital readmissions under subsection (7)(f). Section (8) was amended to clarify short-stay demand and section (9) included under bed inventory determination, beds scheduled to be transferred out of the service area and the definition for required beds. Section (9) amendments included that the applicant must state and justify the occupancy factor used.

- RAC member asked whether the term "only" needs to be included in the sentence, "The Authority will review the proposed multi-county service area and may use that only when the evidence demonstrates that county boundaries do not reflect actual utilization or access. A. Ogston noted that removal of the term "only" would not alter the meaning of language.
- D. Selover recognized RAC member's previous objection to removing the term "set up" beds.
- RAC member expressed confusion about use of three and five years throughout the rule. A. Ogston responded that the usual process is to use the previous three years of utilization data to forecast future use. For population trends, a longer historical period is typically reviewed, often in five-year increments to understand how the population has changed over time. It was further noted that program staff will confirm time frames used in rule text.

- RAC member asked via Chat whether subsection (3)(a) be "licensed beds" not just beds. A. Ogston responded that because the rules allow looking at other beds in certain circumstances, then the term "licensed" should not be included.
- RAC member via Chat indicated that they believed the data required under section (4) should be provided by OHA rather than the applicant and further stated that the rules noted several data sets that could be used by the applicant. Staff responded that sometimes the OHA is a public source of data that is used or the ODHS is a public source of data, but it is the applicant's responsibility to request and obtain the data either through a public records request or other format. It is not the program's responsibility to obtain the data they need; only that it will be released through a public records request if applicable. RAC member expressed concern that the public or other interested parties may not easily have access to the data sources, which is why it would be helpful for OHA to identify the data sources to be used. A. Ogston noted that to the extent an applicant is proposing a different data source, applications are posted on the CN webpage for public awareness. A. Ogston stated that data sources will be considered further.
- RAC member questioned section (5) changing "the Authority" to "Applicant." It was noted that the text should have always stated "the applicant" instead of OHA as it's the applicant's responsibility to conduct the analysis and the OHA verifies the math. It was further noted that the language is redundant and A. Ogston will update.
- RAC member expressed concern about the challenges with the bed-need methodology including requiring calculating utilization based on where a resident lives, rather than where the nursing facility services are provided. Current nursing facility data typically reports facility days or provider days, not resident days broken down by ZIP code or county. It is unclear how to translate nursing facility utilization data into utilization by residence of a specific service area without a patient origin study or resident-location data. Nursing facilities near borders may serve residents from multiple areas, making it difficult to determine which area is being measured. It is uncertain whether there is a comparable data source for nursing facilities with respect to patient origin data. Existing data sources such as cost reports do not appear to include ZIP code information. It's uncertain how short-stay and long-stay residents would be identified and whether

existing data accurately captures resident outcomes and usage patterns. It was noted that additional technical assistance may be needed to determine whether required data exists and how it can be obtained. RAC members were encouraged to share information about data sources if any are known.

- RAC member requested that OHA consider a different word or clarify further the term "extraordinary" used in subsection (7)(b) which seems like too high of a standard.
- RAC member asked for an explanation of how chronic understaffing, referenced in subsection (7)(d), would be used to assess localized constraints, specifically would chronic understaffing be considered evidence that a community needs additional nursing facility capacity or suggests that a new facility may not be sustainable? A. Ogston remarked that understaffing is not intended to automatically support or oppose a new facility. It is meant to provide context when evaluating local capacity constraints and is only one factor alongside others.
- RAC member asked whether under subsection (7)(f) the reference to hospital readmissions reasonably attributable to the unavailability of nursing facility licensed beds was different than local access constraints. A. Ogston noted that all of section (7) is specific to assessing localized access constraints. The RAC member asked for further clarification and it was noted that the intent is to allow applicants to provide evidence showing that people in a particular county or area are experiencing access problems because nursing facility beds are unavailable.
- RAC member proceeded to ask for clarification under subsection (8)(a) relating to short stay demand and why short stay demand forecasting was deleted. It was noted that the changes were clean-up and alignment based on other changes in the rules. RAC member expressed concern with the deletion of hospital discharge volumes because clinically appropriate discharges was not clear to them.
- RAC member reflected that hospital discharge data must be able to be broken down into more specific categories to be meaningful, because the data may count people who are simply returning to a nursing facility where they already lived. To accurately assess demand, the analysis would need to distinguish residents returning to their nursing facility after a hospital stay; individuals entering a nursing facility for a long-term stay, or

patients who need a short-term nursing facility stay for rehabilitation or recovery after hospitalization.

- A. Ogston noted that for paragraph (8)(b)(C), language was added to account for other indicators for future demand besides 75 and older based on previous RAC meetings.
- For paragraph (9)(d)(A), RAC member asked for clarity about the purpose and application of the new occupancy factor, including the rationale for lowering the threshold to 85% and how applicants should determine the appropriate occupancy rate to use in their analysis. Staff responded that the purpose was to take into consideration urban versus rural and alignment with ODHS policy.
- Via Chat, RAC member stated the use of the word "may" is not clear. Does this mean that an applicant could use 75%, or 65%? A minimum floor occupancy % threshold is necessary. RAC member reiterated that if the concept is to identify the floor, the rules should say the applicant must apply an occupancy factor that's equal to or greater than 85%.
- RAC member stated that a floor of 85% would mean that there is no need for nursing facility beds in Oregon. A. Ogston noted that the OHA still can consider local constraints and whether in a particular service area there are licensed beds that are not 'on-line.' It was further noted that rule changes are not just considering today, but creating rules that can be applied in alignment with ODHS and Oregon policy to shift away from nursing facility beds.
- Via Chat, RAC member stated, "On licensed beds, the test returns the same answer everywhere, being no shortfall in any of the twenty-five services areas, whether the county is at 75% or 35%. A measure that cannot distinguish between those two counties is not doing any work. On beds actually in service, the counties that clear are the ones holding capacity offline, which is what we would want the test to find."

OAR 333-610-0070 – Swing Long-Term Care Beds in Hospitals

Subsection (2)(e) was removed based on previous RAC comments. RAC members had no comments.

OAR 333-610-0060 through 0100 –

D. Selover asked if there were any additional comments besides what was shared at the previous RAC meetings.

Statement of Need and Fiscal Impact

Due to lack of time, RAC members were encouraged to review the Statement of Need, Fiscal, and Equity Impact statements and submit suggested comments or revisions by e-mail no later than Friday, October 23rd.

Next steps –

- D. Selover thanked RAC members for their input and noted that staff will review comments from today's meeting and any follow-up written comments to consider additional changes. It was further noted that the initial filing deadline dates may need to be extended out a month based on feedback received.
- RAC members were encouraged to submit any follow-up comments or proposed language changes by email to mellony.c.bernal@oha.oregon.gov, matt.s.gilman@oha.oregon.gov, or sadie.morrissey@oha.oregon.gov no later than Friday, October 23.
- RAC members were encouraged to submit any comments or suggested revisions to the Statement of Need, Fiscal and Equity Impact statements no later than Friday, October 23.
- RAC member asked if there will be an opportunity to run a mock analysis. Staff will consider.

No further meetings are scheduled at this time.